Senate

General Assembly

File No. 14

January Session, 2011

Senate Bill No. 12

Senate, March 1, 2011

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the bill ought to pass.

AN ACT PROHIBITING COPAYMENTS FOR PREVENTIVE CARE SERVICES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective January 1, 2012*) (a) No insurer, health care center, hospital service corporation, medical service corporation, fraternal benefit society or other entity delivering, issuing for delivery, renewing, amending or continuing in this state an individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes shall impose a copayment, deductible or other out-of-pocket expense for preventive care services.

(b) For the purposes of this section, "preventive care services" means: (1) Annual physicals and periodic health evaluations, including test and diagnostic procedures ordered in connection with routine examinations such as annual physicals; (2) routine prenatal and well-child care; (3) child and adult immunizations; (4) tobacco cessation programs; and (5) obesity weight loss programs as prescribed by a

licensed physician. "Preventive care services" do not include any services or benefits to treat an existing illness, injury or condition.

Sec. 2. (NEW) (*Effective January 1, 2012*) (a) No insurer, health care center, hospital service corporation, medical service corporation, fraternal benefit society or other entity delivering, issuing for delivery, renewing, amending or continuing in this state a group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes shall impose a copayment, deductible or other out-of-pocket expense for preventive care services.

(b) For the purposes of this section, "preventive care services" means: (1) Annual physicals and periodic health evaluations, including test and diagnostic procedures ordered in connection with routine examinations such as annual physicals; (2) routine prenatal and well-child care; (3) child and adult immunizations; (4) tobacco cessation programs; and (5) obesity weight loss programs as prescribed by a licensed physician. "Preventive care services" do not include any services or benefits to treat an existing illness, injury or condition.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2012*	New section
Sec. 2	*January 1, 2012*	New section

INS *Joint Favorable*

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 12 $	FY 13 $
State Comptroller - Fringe Benefits	GF , TF- Cost	None	Potential

Note: GF=General Fund, TF = Transportation Fund

Municipal Impact:

Municipalities	Effect	FY 12 $	FY 13 $
Various Municipalities	STATE MANDATE - Cost	Potential	Potential

Explanation

As of July 1, 2010, the State Employees' Health plan went self insured. Pursuant to current federal law, the state's self-insured health plan would be exempt from state health insurance benefit mandates. However, in previous self-funded arrangements the state has traditionally adopted all state mandates. To the extent that the state continues this practice of voluntary mandate adoption, the following impacts would be anticipated.

It is estimated that the state employee health plan will incur an annual cost of approximately $200,000 as a result of eliminating copayments for currently covered preventative services. Costs will begin to accrue in FY 13 upon contract renewal. These cost estimates do not include additional costs for tobacco cessation or obesity weight-loss programs which are currently not covered by the plan, and therefore would be outside of the scope of this mandate. The bill prohibits imposing a copayment for covered preventative care services, however it does not require coverage of preventative services.

The bill's provisions may increase costs to certain fully insured, non-grandfathered municipal plans which include copayments for the

preventative care services specified by the bill and not currently required by the Patient Protection and Affordability Care Act (PPACA) [1,2]. The coverage requirements may result in increased premium costs when municipalities enter into new health insurance contracts after January 1, 2012. Due to federal law, municipalities with self-insured health plans are exempt from state health insurance benefit mandates.

The state employee health plan and many municipal health plans are recognized as "grandfathered" health plans under the PPACA. It is unclear what effect the adoption of certain health mandates will have on the grandfathered status of the state employee health plan or grandfathered municipal plans PPACA[3].

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

The federal health care reform act requires that, effective January 1, 2014, all states must establish a health benefit exchange, which will offer qualified plans that must include a federally defined essential benefits package. While states are allowed to mandate benefits in excess of the basic package, the federal law appears to require the state to pay the cost of any such additional mandated benefits. The extent of

[1] Grandfathered plans include most group insurance plans and some individual health plans created or purchased on or before March 23, 2010. Pursuant to the PPACA, all health plans, including those with grandfathered status are required to provide the following as of September 23, 2010: 1) No lifetime limits on coverage, 2) No rescissions of coverage when individual gets sick or has previously made an unintentional error on an application, and 3) Extension of parents' coverage to young adults until age 26. (www.healthcare.gov)

[2] Pursuant to the PPACA, as of September 23, 2010, all non-grandfathered health plans are required to cover preventative services rated A or B by the U.S. Preventive Services Task Force, with no cost sharing.

[3] According to the PPACA, compared to the plans' policies as of March 23, 2010, grandfathered plans who make any of the following changes within a certain margin may lose their grandfathered status: 1) Significantly cut or reduce benefits, 2) Raise co-insurance charges, 3) Significantly raise co-payment charges, 4) Significantly raise deductibles, 5) Significantly lower employer contributions, and 5) Add or tighten annual limits on what insurer pays. (www.healthcare.gov)

these costs will depend on the mandates included in the federal essential benefit package, which have not yet been determined. Neither the agency nor a mechanism for the state to pay these costs has been established.

In addition, the PPACA requires all plans to cover preventative services by 2014.

OLR Bill Analysis

SB 12

AN ACT PROHIBITING COPAYMENTS FOR PREVENTIVE CARE SERVICES.

SUMMARY:

This bill prohibits certain health insurance policies from imposing a copayment, deductible, or other out-of-pocket expense (e.g., coninsurance) for preventive services. It defines "preventive care services" as:

1. annual physicals and periodic health evaluations, including tests and diagnostic procedures ordered in connection with them;
2. routine prenatal and well-child care;
3. child and adult immunizations;
4. tobacco cessation programs; and
5. obesity weight loss programs prescribed by a licensed physician.

The bill specifies that preventive care services exclude services or benefits intended to treat an existing illness, injury, or condition.

EFFECTIVE DATE: January 1, 2012

APPLICABILITY

The bill applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut on or after January 1, 2012 that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including coverage under an HMO plan.

Due to federal law (ERISA), state insurance benefit mandates do not

apply to self-insured benefit plans.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable
Yea 10 Nay 9 (02/10/2011)